CoLab
Community & Behavioral Health Policy

Culturally Affirming & Responsive MENTAL HEALTH

CARE (Culturally Affirming & Responsive Mental Health) for Kids & Families: Interim Report

Legislative Proviso Funding

Engrossed Substitute Senate Bill 5693, Section 603 (74).

December 15, 2022

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Alfred White
The League of Extraordinary People

CARE Community Sounding Board

We'd like to give a special thanks to the members of our Community Sounding Board, a group of over 60 individuals from across Washington State who have volunteered to share their perspectives and feedback with us throughout the project. Many sounding board members work in behavioral health and/or bring their firsthand, lived experience as a patient or patient caregiver to the process. They are all eager to help expand culturally responsive behavioral healthcare in Washington State.

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Executive Summary

The 2022 Washington State Legislature directed the University of Washington CoLab for Community and Behavioral Health Policy in the Department of Psychiatry and Behavioral Sciences, to facilitate the development of training resources and a training strategy to improve the cultural responsivity of public mental health services for children and youth. Given the complexity and sensitivity of the topic, CoLab is adopting a codesign methodology to ensure the approach is richly informed by multiple perspectives and sources of knowledge.

CoLab's approach to codesign is informed by the principles of coproduction, design thinking, and health services innovation. Coproduction is a public policy term used to describe efforts to bring community members into more direct relationship with policymaking. Design thinking is an approach to innovation development that facilitates human creativity through activities intended to prompt novel problem solving. Health services innovation involves capturing and synthesizing the available scholarly literature and other sources of critical information (e.g., provider viewpoints) to inform design and innovation development.

Decision-making for the CARE project is organized at four levels. The codesign team is a multisector group of 10 individuals, representing lived experience, clinical expertise, research experience, and mental health provider experience. This team is responsible for all of the key decisions for the training materials and strategy. The codesign team was finalized in September and has met four times. The codesign team is supported by an advisory team composed of twenty individuals. The advisory team is also multisector, representing diverse cultural groups, public mental health consumers, provider agencies, payer and state organizations, and clinical and scholarly experts. The advisory team has met twice since September. The community sounding board provides input that is used by the codesign team to guide key decisions. The project has solicited the community sounding board for information once and provides the community sounding board with biweekly project updates. The implementation team is composed of four Accountable Communities of Health who are positioned to bring regional perspectives into the project. The project team held multiple individual meetings with each ACH and two group meetings.

Facilitation of these groups is provided by UW Colab which is supported by five internal teams. The project management team facilitates contracts and payments with external partners as well as oversees project timelines and products. The communication team manages biweekly project updates to CARE listserv, community sounding board, and external outlets (e.g., the .gov delivery system, Department of Psychiatry, social media). The communications team has produced two external partner spotlights, two CoLab team member spotlights, a codesign team spotlight, and two project updates. The information synthesis team manages information flow from the community sounding board and advisory team and brings this into the codesign team. The team has produced a synthesis of the project's first open forum, and the first community sounding board survey (what does culturally responsive mean to you?). The partnership engagement team manages external partnerships, ensuring the project goals are aligning with partner values, and ensuring the project is informed by diverse and representative views. The evaluation and research team gather and synthesizes the scholarly literature to inform design, and is developing an evaluation strategy for the codesign process as well as the developed training strategy.

Progress to date. The project is nearly midway through the first year of planning. Using information from the community sounding board and advisory board, the codesign team has established principles of culturally responsive care. These principles will dictate the specific strategies designed in the training development phase. The codesign team is now evaluating the scholarly literature findings by reviewing clinical care scenarios from the literature through storyboards. The storyboards were developed following a comprehensive review of the literature on clinical care

delivery by non-licensed providers. Responses to these storyboards will dictate the development of training strategies and workforce model.

Next steps. The project team plans to launch a second community sounding board campaign in January to receive feedback on specific clinical care options to expand a culturally representative workforce. Following this campaign, the codesign team will move into prototyping a final set of guidelines for training and workforce expansion. These guidelines will inform the development of specific training guides and implementation strategies for licensed providers, non-masters level providers, and clinical directors. We intend to begin piloting these resources in one or more sites in the summer of 2023.

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Background

Publicly funded behavioral health agencies provide some of the most important and life-saving services to children and families in Washington State. With the impact of the Covid-19 pandemic on mental health, there is growing concern that the current system cannot adequately support community needs. Further, given the pandemic's disproportionate impact on Black, Indigenous, Person of Color (BIPOC) communities, ensuring the cultural responsiveness of mental health services is critical. It must be a top priority to ensure community access to culturally relevant, child-centered, and adaptable care that truly meets individual and family needs.

As a first step in informing how to better support community mental health needs for kids and families, CoLab hosted three meetings in the summer of 2021. We brought together multi-sector partners involved in the public behavioral health system to discuss ways to improve services for kids and families in our state. The meetings included folks from Accountable Communities of Health, managed care organizations, the Washington State Legislature, public health policy organizations, Health Care Authority, King County Behavioral Health, and others from across Washington state. Through a facilitated, participatory design process, the group named many priority areas for children's behavioral health care, including health equity, trauma-informed care, person-centered approaches, best practices for brief interventions, integrated care, measurement-based care, clinical supervision, using data to improve outcomes, and focusing on effective evidenced-based components to better serve diverse populations.

The group identified that one of the biggest challenges facing behavioral health agencies was workforce shortage and retention issues. It felt important that possible models or interventions developed through this group would alleviate, or would at least not exacerbate, the overwhelm many agencies were experiencing. The group acknowledged that many organizations were already doing incredible work to improve children's behavioral health services in Washington, and that it would be critical to partner, bridge, and defragment these efforts to ensure we don't duplicate existing work. Collaboration and partnership around the work was identified as key to effecting meaningful community change.

Given the current landscape of Washington's behavioral health system, this multi-sector group of thought leaders in Washington State requested a plan that would strengthen public behavioral systems using a three-pronged strategy:

1) Provide organizational support to public behavioral health agency leaders;

2) Develop a training strategy to increase culturally relevant and evidence-informed treatment; and

3) Support an expansion of the workforce to include non-masters level providers with lived experience to deliver these treatments.

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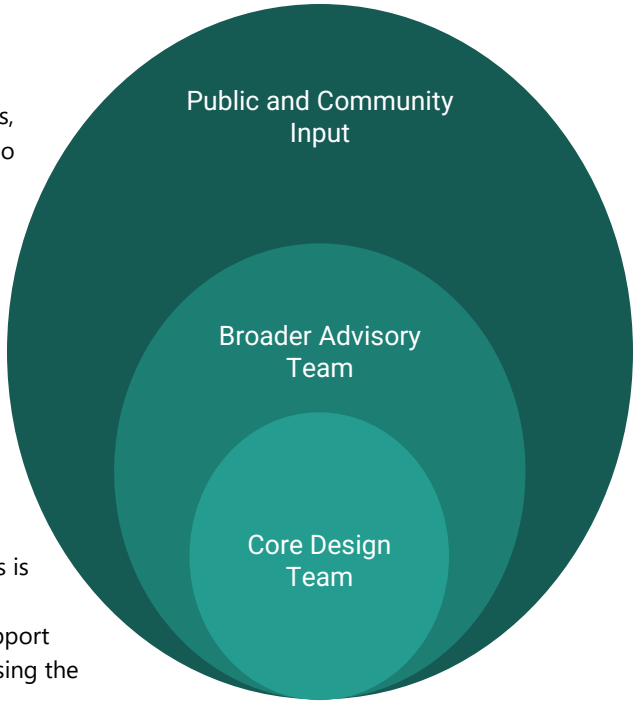
Our ultimate goal is to implement this culturally responsive curriculum at scale with over 100 community mental/behavioral health centers and other primary care sites, reaching all contracted Medicaid agencies. We'll support self-directed learning and peer learning communities and will provide one-on-one coaching for clinic leaders and other members of the organization.

Organizing Framework: Codesign



CoLab staff has worked to build partnerships, build out the design teams, and spread the word across Washington state to ensure that anyone who wants to be involved, can be. The CARE project places individuals and communities who would be most impacted by these policies at the center of the design process, ensuring that it is directly informed by their lived expertise and experience.

In this first phase of Codesign we are focusing on designing an approach that reflects the input of BIPOC communities seeking public behavioral health services. We brought together a design team (Community Coalition) that reflects areas of expertise relevant to this issue, including those representing community and lived experience (see figure). Codesign facilitation is being conducted by a non-Washington State public health system design organization. The process is intended to produce 1) a culturally responsive curriculum to train an expanded child/family mental health workforce; 2) an organizational support strategy to support agencies to hire and train an expanded workforce using the developed model; 3) a regional implementation strategy.

Codesign will proceed over one year in the following, estimated, time frames per phase: Values Mapping (2 months), Knowledge gathering and integration (6 months), Prototyping and Idea testing (beta-testing) (4 months). During this first 6 months we have worked on values mapping and information gathering, during the next 6 months we will continue to gather and integrate knowledge as we move to prototyping and beta testing.

The project values, which were identified by all partners throughout the planning process, include transparency, co-creation, community ownership and centering community lived experience. Informed by feedback from multi-sector groups of behavioral health providers, health equity and organizational change management experts.

To determine design values, the codesign team was asked to consider the following prompts:

- How broad can a culturally responsive training approach be? Are there general principles that can improve care or do clinical approaches need to be tailored to cultural group?

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- How much of culturally responsive care is training on key principles vs. an ongoing process of local community engagement and review of practices?
- What organizations and trainers will the Community Coalition work with to develop and implement the products from this effort?
- How can this approach be successfully used with agencies that are not interested in the need to seriously consider culturally responsive care and shift business models accordingly? Or can it?
- What organizational training or strategies will be needed to build leadership, financial, and motivational capacity for implementing the changes the coalition articulates as necessary?

Through information gathering, the coalition is identifying relevant categories of expertise and knowledge that will be used in the next phase to guide design. Members are asked to stay in a "discovery" mindset in this phase to support the agreement to gather information that may be outside of individual members' frameworks or pre-identified beliefs about what the product and approach should look like. The facilitator supports the group to define these buckets of information/expertise as well as how they will be captured and synthesized. Our approach to evidence synthesis and integration is expanded upon in the section below in addition to further elaboration on the crucial partnership engagement activities in which evidence, information, expertise, and experience are all integrated to form the basis for curriculum design and overall approach

Approach

Partnership levels

We have implemented several levels of partner engagement to inform the design of the curriculum including a community sounding board, an advisory team, a codesign team, and an implementation team. Each of these groups serves a vital role in directing and informing the design process and are described in greater detail below.

Community sounding board. The community sounding board is a broad ranging group of individuals who have volunteered to share their feedback with us throughout the project. Members were identified through direct outreach and communications with our extended networks and systems partners. We currently have 61 members. Their first question to respond to was "What does culturally responsive mental healthcare mean to you?". We collected responses from each member and shared them with the codesign team for further synthesis and integration into the group's guiding principles.

Advisory Team. The purpose of the Advisory Team is to bring together a group of community members with different areas of expertise and experience across behavioral health/mental health systems, healthcare, clinical work, cultural responsivity, policy, health equity, public health, and other related disciplines. The purpose of this group is to support the core codesign team, which is the smaller, ten-person core group that will hold much of the design process and determine the course of this initiative from the ground up. Ideally, a successful advisory team will be one that can be responsive to requests from the codesign group for ideas around information, community organizations or connections, and be general thought partners around project vision and feasibility. This might look like gathering information for the codesign group on a particular topic, sharing your own relevant experience around a question or idea from the codesign group, or suggesting a connection that the group feels would be helpful in the project process.

The first advisory meeting was held on October 13th, 2022. During the we presented an overview of CARE. Topics discussed during the meeting were: "What is your personal experience with trainings on culturally specific approaches to mental health care (e.g., manuals tailored to a specific cultural group) and trainings that are broader in scope (e.g., a framework for how to talk about culture with a client and how to shape services as a result but not directive about practice techniques) and "What benefits and harms do you anticipate either approach having when thinking about a therapist serving multiple clients with diverse cultural backgrounds."

Advisory Team Members and Professional Affiliations:

Melody McKee Behavioral Health Institute, Dr. Someireh Amirfaiz New Americans Alliance- for Policy and Research, Erika Crable UC San Diego, Ben Danielson AHSHAY Allies in Healthier Systems for Health and Abundance in Youth, Gregory Aarons Department of Psychiatry at The University of California, San Diego, Makinie Fortino Deconstructing the Mental Health System, Libby Hein Molina Healthcare, Naisha K. Williams Washington State Department of Health, Paul Davis Health Care Authority Division of Behavioral Health and Recovery, Idabelle Fosse Public Health – Seattle & King County, Ray Hsiao Asian Counseling and Referral Service, Terry Lee Community Health Plan of Washington, Laurie Lippold Partners for Our Children, Tyus Reed Spark Peer Learning Center, Georganna Sedlar Professor at University of Washington, Larry Wissow University of Washington, Seattle Children's Hospital, Jasmin Vidal Spark, Jim Theofelis NorthStar Advocates.

Codesign team. The Codesign team is a core group of ten individuals who are responsible for collectively developing materials and products to achieve the three major aims of the CARE project (see above). This group was recruited from across Washington State to bring a broad range of lived and professional expertise in relevant areas of behavioral and mental health, research, health equity, anti-racism, healthcare, social services and non-profit work. The codesign team regularly consults with the advisory team and community sounding board to inform key decisions throughout the design process but is ultimately accountable for final design decisions. The overall goal of the

codesign team and their collaboration with the advisory team and sounding board is to ensure that the results of this process are grounded in community lived experience, the research evidence, and policy.

The codesign team currently meets bi-weekly for 1.5 hour facilitated design sessions, which include activities such as empathy mapping, personal storytelling, identifying key values, defining cultural responsivity, and exploring different models of behavioral health care for the licensed and non-licensed workforce. Codesign is a collaborative, community-centered design process that includes four phases: value mapping, information gathering, prototyping, and beta testing. The codesign team completed the value mapping phase over multiple meetings to identify guiding principles for the initiative, and is currently in the information gathering phase. In this phase, the codesign team will synthesize data from the literature, from their own lived experience, the advisory team, sounding board, and other sources as needed to inform the development of a culturally responsive curriculum and lived experience workforce strategy.

Codesign team members and professional affiliations:

Zalina Abner-Green, King County Public Health; Someireh Amirfaiz, New Americans Alliance for Policy and Research; Shayla Collins, Community advocate; Carolyn Cox, SPARK Peer Learning Center; Gabriel Hamilton, SPARK Peer Learning Center; Rickey "Deekon" Jones, New Developed Nations; Avreayl Jacobsen, King County Mental Health; Georganna Sedlar, UW; Cindy Trevino, Seattle Children's Hospital; Trenecsia Wilson, Community psychotherapist;

Implementation team. The purpose of the CARE Implementation team is to develop a foundational plan for how to implement the project objectives, products and policies at scale across the state. These products will be developed out of the codesign team, and it is important to ensure that all Washingtonians have equitable access to the resources once developed. Over the course of the last five months, the CARE team has built relationships with members of Washington State Accountable Communities of Health (ACHs) to build the CARE implementation team. ACHs are regional public health hubs that work directly with community members and organizations to promote health equity and access to care, and the CARE team identified them as key partners in implementation because of their strong relationships with local community. Through this model, the implementation team aims to plan and ultimately roll out a strategy for licensed and non-licensed providers to utilize the developed culturally responsive curricula across Washington State. As part of an ongoing feedback loop to ensure the project is community-centered and relevant, the ACHs will also hold community listening sessions and gather information from community partners to inform the CARE project products.

During the first Implementation Team meeting on October 20th, 2022, we brought all of the team members together to discuss the vision for statewide policy implementation and gathered feedback on potential barriers to scaling the CARE project curricula and policies statewide. Through discussion, we determined that ACHs would facilitate community listening sessions in order to inform key decisions in the implementation strategy moving forward and how strategy may differ depending on region. The next Implementation team meeting is scheduled for December 15th, 2022, and will continue to meet bi-monthly in 2023.

Implementation team members and professional affiliations:

PARK Peer Learning Center: Carolyn Cox, Gabriel Hamilton; Better Health Together ACH: Sarah Bollig Dorn, Hannah Klassen, Charisse Pope, Alethea Dumas, hadley Morrow; North Sound ACH: Lindsay Knaus, Liz Baxter; Greater Health Now: Sharon Brown, Rebecca Betts.

Communications

Since July 2022, the CARE team has been following a two-way, strategic communications plan to encourage statewide participation in the CARE project and raise the visibility of organizations doing innovative work in culturally responsive mental health, while also soliciting and incorporating public feedback.

Our focus has been on digital communications (blog posts, emails, social media posts, etc.) shared via CoLab's website and listserv. We've created a sharable digital toolkit and other online resources to make it easy for others to help us share information and opportunities to get involved and have been able to have been able to reach a much wider audience thanks to help from our system partners (such as HCA) and volunteer Project Amplifiers.

In addition to our public communications, we've built up an audience of over 300 contacts who have opted in to receive biweekly updates on the CARE project. Through this "CARE News" channel, we've provided regular progress updates, interviews with team members, and spotlight pieces featuring some of our community partner organizations doing innovative work in culturally responsive mental health (for example, DMHS: Deconstructing the Mental Health System). Report data has shown that our audience is particularly interested in our community partner spotlights, so we plan to do more of those stories in 2023.

Evidence synthesis

We conducted a scoping review to explore the literature on therapeutic interventions currently being delivered in the broader community via non-specialist providers to support child and adolescent mental health. The goal of the review was to identify what elements constitute a child- and adolescent-focused treatment “package” delivered via non-specialists, whether interventions are specific to diagnoses, and if a collaborative care approach is necessary for the supervision of non-licensed providers. While a task-sharing model provides a helpful framework for the delivery of intervention via non-specialist, our review reflected on findings that include service delivery via any non-licensed workforce in a community context (e.g., community health workers, lay counselors, peer support).

The approach to the scoping review was based on the guidance of the Joanna Briggs Institute method (Khalil et al., 2016; Peters et al., 2015) with the goal of identifying characteristics of non-specialist workforce service models for child and adolescent mental health. The process will include: (1) identifying the research question, (2) systematically searching for relevant studies, (3) screening and selecting studies, (4) charting the data, and (5) collating the results. Findings were grouped into key concepts and used to inform a best practice model child and adolescent mental health services delivered via non-specialist providers. The searches were limited to work published since the year 2005 at which time the WHO child mental health atlas was published. Studies were eligible to be included in the review based on the following criteria: ability to obtain English translation, youth age ranged from 2 to 24 years old, intervention primary outcomes included child and adolescent mental health, interventions included mental health-specific training (not only problem solving), intervention delivered in community, description of teaching methods included in article, care delivered by non-specialist with no prior mental health training.

A total of 799 articles were retrieved through searchers on several scholarly databases, including PsychInfo, Academic Search Complete, Medline, ERIC, and PubMed. Of the total articles, 226 were moved as duplicates, resulting in 573 articles to review by abstract. Based on pre-determined inclusion and exclusion criteria, 466 articles were excluded by abstract. The remaining 107 articles were screened by full text. After full text screening, 21 articles were identified as meeting eligibility criteria. Articles were summarized and coded to reflect key questions for the review (type and format of intervention, mode of delivery, type of workers, supervision model, training and fidelity approach, study sample, outcomes of interest, key findings). Articles were then double coded by a subject matter expert and the codebook was refined. Major themes were developed from the coded articles.

Preliminary findings of the review provided evidence for three main models of a non-specialist workforce, include caregiver peer support workers (i.e., trained caregivers with lived experience delivering services to other caregivers, community health workers (i.e., trained community members with shared background delivering services to caregivers and youth, and youth workers (i.e., young adults with lived experience delivering services to adolescents). These models were translated into a storyboard format to visually communicate findings of the review to members of the codesign, advisory, and community sounding boards. Members across these boards will be given the opportunity to engage in participatory dialogue to support the design and planning of a model for WA youth behavioral health system and determine which elements of the literature evidence could be used to inform the model of care.

Information synthesis

In June 2022, we held our first public forum to hear from community members on any initial thoughts, hesitations, and guidance on the Culturally Affirming and Responsive Mental Health (CARE) for Kids and Families initiative. Responses were gathered through an online ranking system called Mentimeter and shared during the meeting. We also recorded the meeting with permission from attendees to upload and share with other community members who were unable to attend.

During the meeting, we had 13 participants who responded to the following questions:

"What kinds of practices do we need to put in place to ensure transparency with the public/community?" and "What kinds of questions do we want to ask community to inform this project?" From the responses that we received; five major themes arose:

1. **Public Forums.** The need to have open and public forums for community and system partners to increase transparency and provide frequent updates and opportunities for community members to provide input. CoLab plans to address this theme by hosting a community sounding board, advisory team meetings, and more public forums throughout the project.
2. **Routine Process**. Routine processes and check-ins with community arose as another theme; suggestions for regular communication updates to increase accountability transparency, and updates with the community. CoLab is working on planning regular newsletter updates and meeting check-ins that are frequent with key information without becoming overwhelming.
3. **Community Involvement.** Another theme that people called out was community involvement and keeping community involved and engaged throughout the entire process and including youth. CoLab reached out to representatives and leaders from various community groups to join at every level (codesign, advisory, etc.) and

we also partnered with SPARK to include youth leaders at every level throughout the process as well. We also use the community sounding board to update community and provide valuable feedback on decision making.

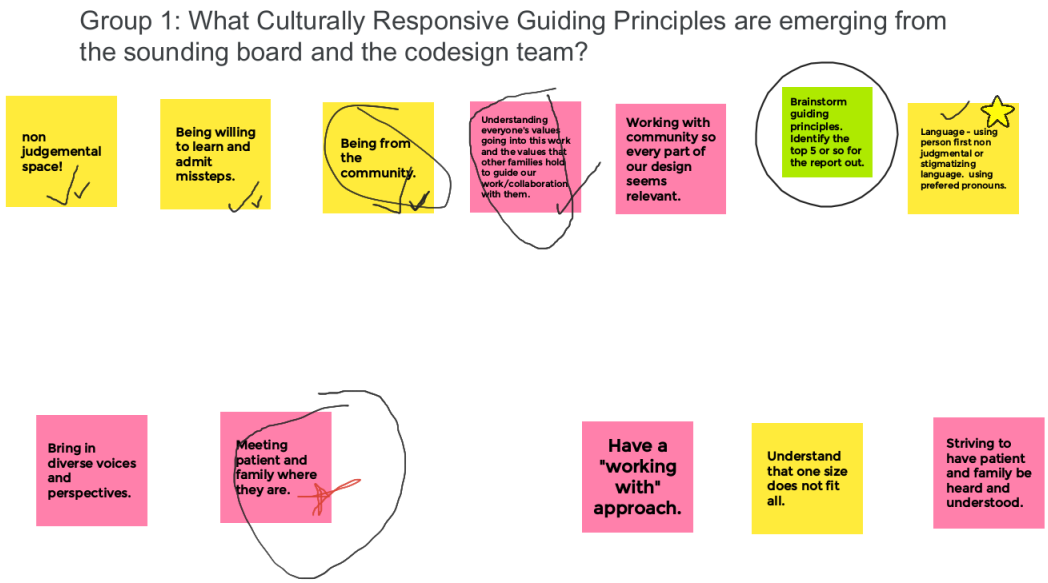
4. **Honesty in Answers & Room for Dissent**. Safe spaces to share honest feedback arose as a theme as well to ensure that people feel safe sharing their honest thoughts. CoLab is working on establishing group values and discussion agreements before the process begins.
5. **Multiple Platforms.** The last theme from responses included having multiple platforms and using a variety of methods to solicit feedback, provide updates, and publicize this project and meetings. CoLab plans to disseminate regular updates through multiple formats (newsletters, videos, etc.) through numerous platforms (emails, webpages, Twitter updates). CoLab also gathered a list of project amplifiers; individuals and organizations who are invested in the CARE project and support by sending out updates and important meeting information to help advertise.

We created a document with links to the recording, themes that arose, and how CoLab is addressing each theme. [The document can be found here.] The document was sent to community sounding board members, uploaded to our website, and will be sent through our newsletter as well.

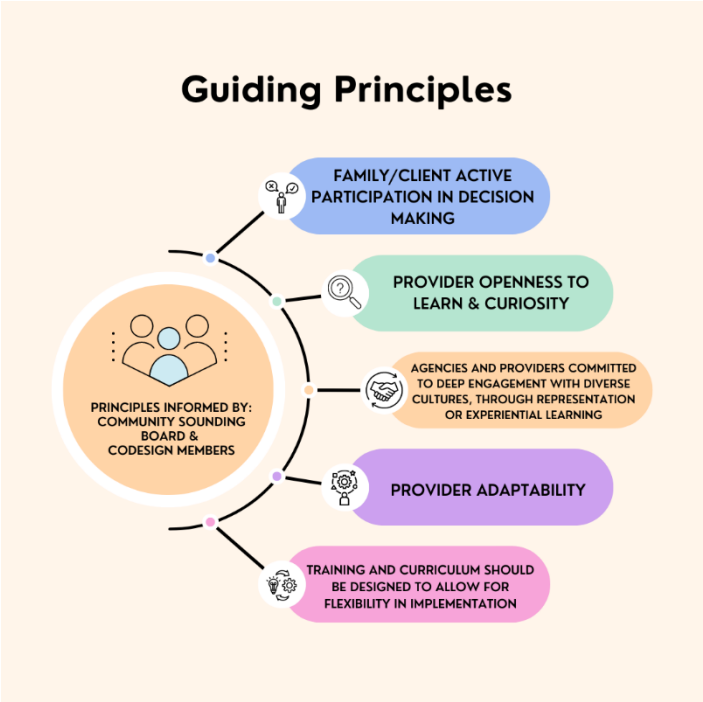
As part of our process, we invited interested individuals to provide feedback through the community sounding board. We asked community sounding board members to answer the question, "What is culturally responsive mental healthcare to you?" and received 59 responses. Community sounding board members also had the option to self-identify (caregiver, provider, a person with lived experience seeking care, a person who attempted and been unable to access care and public services, a person with no experience seeking care, low-income, a person with disabilities, a part of the LGBTQIA+ community, race/ethnicity, and their age).

Each response was converted to a visual quote with information if they self-identified and provided 5-6 visual quotes for each codesign member to look through. We also provided the codesign team with an anonymized version of the responses if they preferred to see the quotes in that format about a week before the next upcoming codesign meeting. Each codesign team member was asked to look over the responses and bring any thoughts to the meeting. An example of the visual quote given to the codesign members can be seen below:

During the codesign meeting, the codesign team split into two smaller groups to discuss what they thought about the responses and if any major themes appeared. Themes were written on a virtual white board, which became guiding principles for this project. Then codesign members were asked to indicate (through a mark or a sticker or via chat) which were their top three guiding principles that were most important to them. Below is a figure of the session with codesign members choices.



An information synthesis team comprised of three CoLab members then organized each guiding principle in order of most votes to least number of votes. Then, each member individually coded the top five guiding principles to avoid bias from seeing each other's responses. The team came together and reconciled any differences. The five guiding principles were presented to the codesign team for confirmation if they reflected their original responses and guide the project. Below are the top five guiding principles.



For transparency and accountability, CoLab sent out an update to community sounding board members to express gratitude and update them on how their responses were used. To further increase anonymity, we sent an example of the visual quotes to the community sounding board without any self-identified information (figure below) and the five guiding principles image. Here is the community sounding board update that was sent out.

CoLab also plans to send out updates via the newsletter and update the webpage with this information as well. There is also a plan to reach out to community sounding board members again in January 2023 with another opportunity to provide feedback and guidance.

Next Steps

Over the next six months we will continue to hold design sessions biweekly, roughly eight more sessions, the advisory team will continue meeting bimonthly, about three more times, and the community sounding board will be engaged twice more with prompting questions or for their responses to potential products developed by the codesign team.

Additional activities for this period will include prototyping and beta-testing.

Prototyping. In the prototyping phase, the codesign team will engage in creative design activities to synthesize information that has been gathered and brainstorm solutions that attempt to address key principles articulated from the information gathering and values mapping phases. The activities employed to support codesign teams to prototype solutions are tailored to the size, preferences, and goals of team. This may include pairing members to generate solutions and conducting round robin review of proposals, iterative refinement, and ranking proposals against the original group values and goals.

Beta-testing. Beta testing involves expanding the circle of feedback from relevant parties and inviting review and comment on the priority plan(s). This is typically conducted using multiple techniques best suited to the groups (e.g., policy makers, system administrators and providers, lived experience, clinical research community, health equity scholars). Based on the nature of the groups being reached, a plan for how to gather their feedback will be developed.

Summary of expected products by June

We will produce written guidance for organizational support strategies (e.g., training and coaching of clinical agency leaders); written guidance for master's level providers (e.g., how to deliver or refer to culturally responsive services); written guidance for non-licensed workforce roles (training resources, e.g., clinical protocols for group or brief mental health support services) and implementation strategies for rolling out these strategies regionally in Washington State.

Expected activities post June 2022

In the piloting phase, the Community Coalition (CC) will work with up to five Accountable Communities of Health to implement the training and support "package" in five mental health organizations. Selection of the participating centers will be jointly determined by the Community Coalition and the ACHs with consideration for fit, interest, need and capacity. In the remaining phases of implementation, the Community Coalition will shift to a steering committee with a chairperson and paid staff member who will coordinate communications among the CC, the ACHs, and the training organizations selected in the codesign phase.

Implementation will be informed by an "adaptive" training model in which local sites will review the curriculum and identify areas of redesign to suit local needs while adhering to the core principles and goals articulated by the Community Coalition. Pilot implementation will proceed over six months, after which, each site will report back to the CC the strengths and weaknesses of the approach.

The CC will review this feedback to assess whether there is a need to change any portions of the core model or implementation strategy. The CC will then move the project into the large-scale implementation phase consisting of three activities: 1) Self-guided, digital resources; 2) Learning communities; 3) Personalized organizational support.

The final implementation plan will be determined by the Community Coalition. The implementation plan outlined below is informed by emerging research and best practice models for large-scale implementation. The codesign team will consider this research in determining whether the following or improved strategy will be employed in the implementation phase.

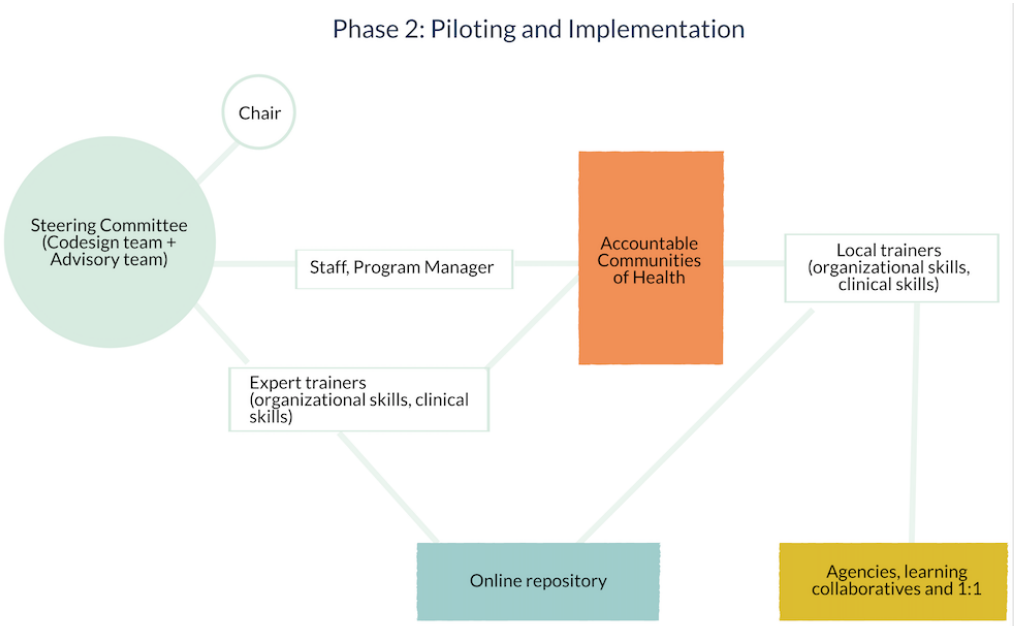
Online repository. All of the materials developed to facilitate local site implementation will be stored online and accessible to the public. The CC and training organizations will develop adaptations to clinical or organizational guidance materials to make them more usable for individual (self-guided) use. For example, this may include a "how to use" section before a clinical guidebook; or asynchronous videos with role plays and guidance about how to use the materials.

Learning communities. The learning community approach will use the "cascade" model of training in which Accountable Communities of Health will serve as training and support hubs for local agencies in their region. Cascade models build training competencies across a cascade of care (clinical experts, to local trainers, to direct staff). In this project, a central training group (CC_trainers) will co-train the ACHs and a locally identified trainer from each region in the clinical and organizational support approaches. The CC-training organization will support an ongoing learning community with all regional L-trainers with case-based discussion, workshops, and booster sessions on clinical and organizational topics. The local trainer will work with local agencies to set up agency-based peer consultation teams after providing live training for the first cohort of employees in the agency. Following demonstration of competency, the local agencies will take over training new, incoming workforce along with the self-guided materials provided in the online repository. The local trainer will provide agency-level boosters and site level assessments of local agency competency at routine intervals.

Personalized organizational support. In addition to learning communities, the CC-training organization and local trainers will collaborate to provide organizational support to agencies seeking support or nominated by the ACH to receive more in-depth support in bringing on an expanded workforce and implementing the culturally responsive model. This will be provided to three organizations at a time over six months and will extend over three cohorts.

Evaluation of the project will include measures assessing the success of implementation, the integration of new positions within mental health organizations, and feedback from individuals using mental health services on how well services met their expectations. The Community Coalition will choose an evaluation partner in the codesign phase and will look for a partner with experience conducting system-level and clinical outcome evaluations with a focus on behavioral health. The Community Coalition and evaluation partner will work closely to refine the outcomes listed below, the evaluation strategy, and the recommendations.

Implementation success. Implementation success will be measured by the rate of engagement in training by local agencies (% of eligible trainees who engaged), the engagement and competency of the local trainers as assessed by the CC-training organization, and ***the number of clients served by direct service providers.***



In phase 2, the Community Coalition will work with the Accountable Communities of Health to pilot the model in five mental health organizations, after which the Community Coalition will transition into a Steering Committee led by a chairperson. This training will be piloted for six months, during which the the curriculum will be reviewed and redesigned to suit agency-specific needs and adapt to real-world conditions. After the pilot, the adapted materials will be shared on an online repository accessible to the public. Learning communities will use the "cascade model" to support ACHs in training local behavioral health agencies across the state, and scaling up the implementation of the developed training model.

Organizational outcomes. Organizational shifts will be measured by ***the increase in the lived experience workforce*** within participating agencies, feedback from all clinical workforce on the cultural responsivity of the agency, and satisfaction with the organizational support provided by the project.

Client feedback. Part of the codesign process will identify what client measures are most appropriate for the training initiative and implementation will ***include obtaining feedback from clients on their experiences with mental health care***. This information will be de-identified and aggregated at the agency level to assess client satisfaction and progress towards mental health goals.

Conclusions

The project has been largely successful in attracting diverse partners, representing diverse cultural communities as well as diverse sectors along the continuum of service delivery (clients, providers, payers, state, legislative). The project has struggled to recruit robust representation from tribal nations in Washington State. We are currently being advised by Lucille Mendoza from the Health Care Authority on approaches for strengthening this connection.

The facilitation team is also responding to feedback from the codesign team about the structure of team meetings. A common request was to provide more consistent and clear information in these meetings about how codesign team activities were informing product development.

The CARE codesign process is on track to produce training guides and implementation strategies for licensed clinicians, non-masters level providers, and clinical directors by summer 2023. We intend to partner with Accountable Communities of Health as regional implementation partners to roll out the strategies. In 2023/24 the UW CoLab team is intending to turn over strategic direction of the project to a training organization who will be responsible for facilitating local, ongoing implementation efforts.